HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

April 27, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

UPDATES FROM THE NEW JERSEY MEDICAL ASSISTANCE ADVISORY COUNCIL

This week, our *In Focus* section comes to us from HMA Principal Karen Brodsky, who reviews a number of important updates from New Jersey's Medical Assistance Advisory Council (MAAC) quarterly meeting on April 20, 2016.

Medicaid Accountable Care Organizations Update

Tyla Housman, Senior Director from the New Jersey Health Care Quality Institute introduced the three Medicaid ACOs that were approved by the

Division of Medical Assistance and Health Services (DMAHS) for Medicaid ACO demonstrations. These are:

1. Camden Coalition of Healthcare Providers
2. Healthy Greater Newark Accountable Care Organization
3. Trenton Health Team

Camden Coalition leaders, Mark Humowiecki, General Counsel and Director of External Affairs and Renee Murray, Associate Clinical Director presented. The Camden Coalition advocates for more collaboration instead of competition to deliver better care at lower cost. They describe some of their efforts under the ACO demonstration, including:

- Working with the online service, Aunt Bertha, to create a social services tool tailored to their work;
- Investing in data and health information exchange to design structured interventions for high-utilizers. In addition to clinical data, the Camden Coalition looks at other data sources including, for example, homeless, educational, corrections and hospital data.
- Driving quality improvement. They cover approximately 37,000 Medicaid enrollees and have contracted with two Medicaid MCOs to help in this effort. The Camden Coalition conducts about 1,000 Medicaid satisfaction surveys a year. They also enter into a seven-day pledge with PCPs to follow up on inpatient discharges. This quality improvement initiative has led to an increase in patients keeping post-discharge PCP appointments within seven days from 18 percent to 40 percent.
- Launch of a Housing First initiative for homeless patients.

The Camden Coalition plans to explore many other innovative models of care to benefit their patients.

Healthy Greater Newark **ACO's** interim Executive Director, Colleen Woods provided an introduction to this ACO. The Healthy Greater Newark Coalition was established in 2008 and its regional ACO covers zip codes 07103, 07108 and 07112 in Newark, the zip codes in the regions that incur the highest rate of hospital and emergency room admissions. Organizational members include:

- 3 hospitals: Newark Beth Israel, Children's Hospital of New Jersey, and University Hospital, St. Michaels;
- 3 primary care sites: Newark community health centers, City of Newark FQHC, Rutgers Medical School
- 3 behavioral health provider organizations: East Orange, University Behavioral Health, Integrity House
- Community based organizations: Clear View Baptist Church, Urban League of Essex County, Visiting Nurses Association HG

This ACO's patient population stands at 41,712 with a median age of 20. It will place a particular emphasis on addressing the needs of pediatric high utilizers, and recognizes the prominence of behavioral health issues across its target population. It plans to target asthma, obesity, diabetes and complex conditions in children, and hypertension, diabetes, heart disease, cancer, obesity, depression and tobacco use in adults.

Trenton Health Team's Executive Director, Greg Paulson, introduced the Trenton Health Team as an organization that came together nearly 10 years ago at a time when the Capital Health System decided to close Mercer Hospital in Trenton. That event brought the clinical providers in the community together in partnership with city government to discuss how to address the ongoing medical needs of its residents. It now includes 50 local partners and serves 38,000 Medicaid beneficiaries and is running a regional ACO. Its partners include:

- 2 hospitals (Capital Health and St. Francis Medical Center)
- 1 FQHC (Henry J. Austin Medical Center), and the
- City of Trenton through its Department of Health and Human Services

The Supports Program Update

Liz Shea, Assistant Commissioner of the Division of Developmental Disabilities gave an update to the MAAC on the Supports Program. She explained the purpose of the program, launched in July 2015, as a state initiative included in the Comprehensive Medicaid Waiver to provide supports and services for adult individuals, 21 and older, with developmental disabilities and living with their families or in other unlicensed settings. It provides employment/day services and individual/family support services based on an individual's assessed level of need. The Supports Program enrolled approximately 100 people into the first cohort in July 2015. This included new services and reimbursement rates, with providers billing Medicaid FFS. Cohort 1 experienced some provider claiming issues that were attributed to "old Medicaid coding" as well as some challenges with the billing numbers for some service authorizations. The billing issues were mostly resolved by the fall 2015 and the second cohort enrolled (about 200 people) in February 2016.

CMS approved amendments to the Supports Program on February 11, 2016. The amendments changed the terms of eligibility whereby individuals no longer have to exhaust an educational entitlement; now eligibility is age based only (at 21 or over) for individuals who are eligible for Medicaid and enrolled with DDD. It also includes the provision to align with the income requirements of the Community Care Waiver that enables individuals in the Supports Program who require private duty nursing (PDN) services to access those services from Medicaid Managed Care while still accessing Division-funded services via the Supports Program, affecting about 120 people. This is referred to as "Supports Program Plus PDN." The amendment also included a provision that enables individuals deemed "Non-Disabled Adult Child (non-DACs)" by the Division to access Medicaid and enroll in the Supports Program.

Beginning April 2016 all new DDD enrollees will be enrolled directly into the Supports Program without requiring interim arrangements for access, with limited exceptions.

Managed Long Term Services and Supports (MLTSS) Update

Stuart Dubin from DMAHS provided updated data on the MLTSS program experience. As of February 2016, 37.5 percent of all MLTSS program members were receiving home and community-based services (HCBS); fewer than 30 percent of MLTSS program members were in HCBS at the program's inception. By contrast, the nursing facility population is down by over 1,000 individuals since the July 2014 implementation of MLTSS. A total of 46,531 Medicaid

enrollees were receiving long term care as of February 2016, with 24,122 (or 52 percent) under MLTSS. The portion of individuals receiving long term care under Medicaid FFS has fallen by approximately 9 percent while the MLTSS population has nearly doubled.

The following charts provide a breakout of New Jersey's Medicaid waiver population allocation as of March 11, 2016 (Figure 1), and their service use and cost by service type in state fiscal year 2015 (Figure 2)

Figure 1 – New Jersey Medicaid Waiver Population Allocation

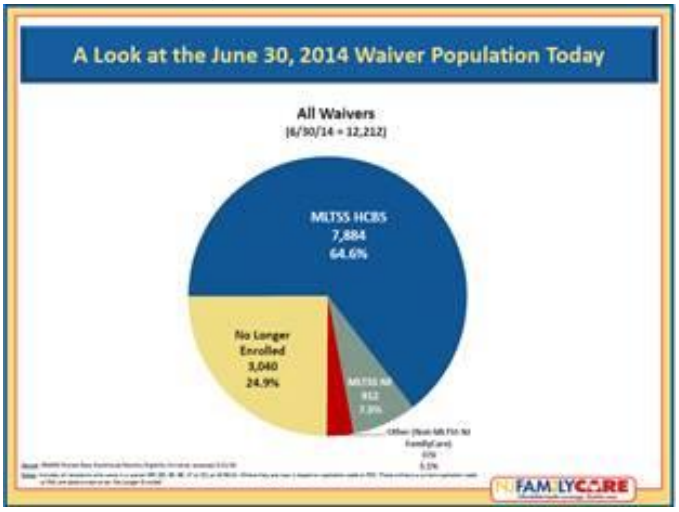
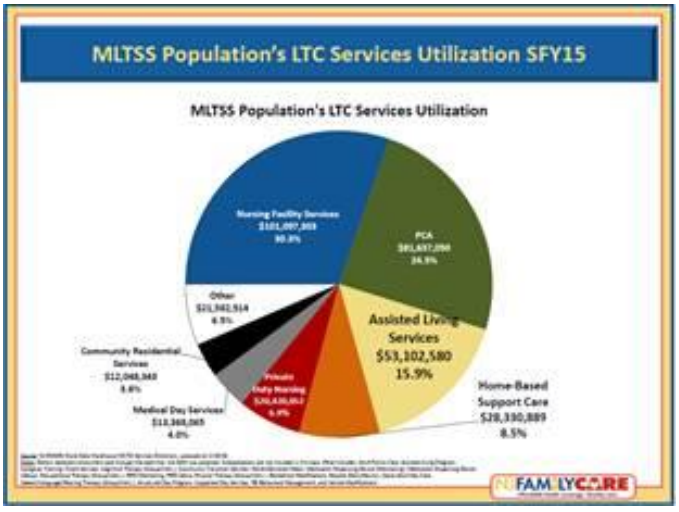


Figure 2 – MLTSS Service Use and Cost by Service Type



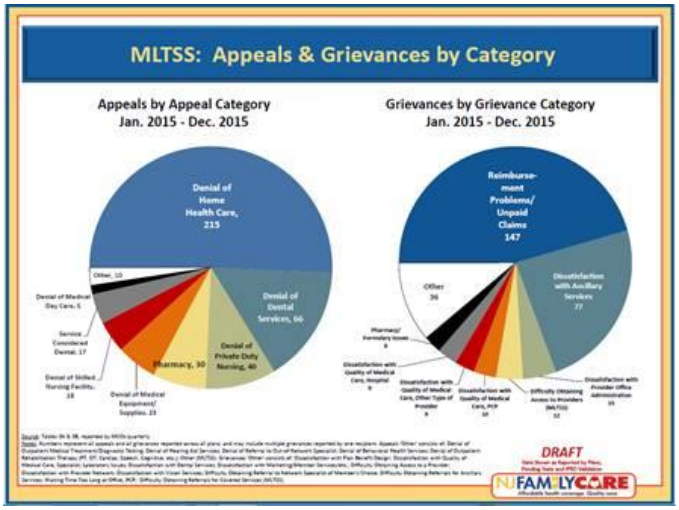
In response to a question from a meeting participant, Mr. Dubin reported that the state has not seen a "wood work" effect in MLTSS and attributed the increases in enrollment to normal aging and service need as determined from assessments of existing managed care enrollees.

Carol Grant, Deputy Director and Maribeth Robenolt, MLTSS Quality Monitoring lead provided an update on the MLTSS complaints, grievances and appeals by category in 2015. The top three member complaints received by the state were for 1) general dissatisfaction (e.g. with care manager); 2) dissatisfaction with ancillary services; and 3) enrollment issues. The top complaints received by MCOs were for: 1) dental denials; 2) pharmacy benefits;

3) administrative complaints (e.g., claims related); 4) dissatisfaction with provider services; and 5) dissatisfaction with dental provider services.

The distribution of appeals and grievances reviewed by the MCOs in 2015 are detailed in Figure 3 below.

Figure 3 – MLTSS Appeals and Grievances by Category

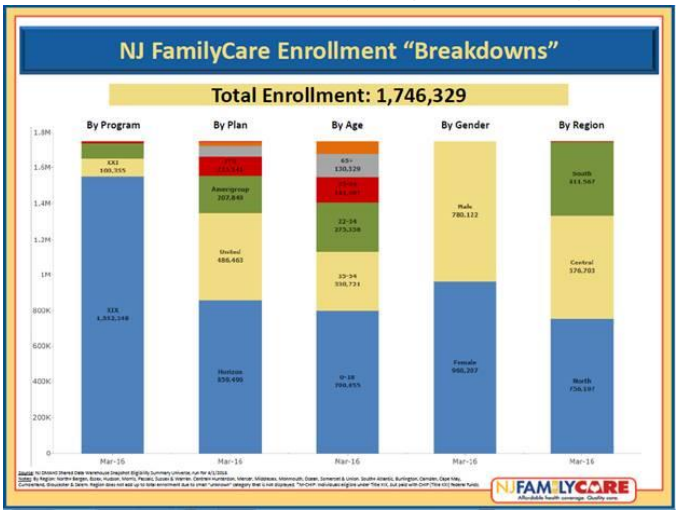


While appeals and grievances have been low relative to the volume of services provided, home health care services received a disproportionately high number of appeals. The chart does not reflect the number of appeals that were also reviewed by the state's Medicaid Fair Hearing process. The vast majority of home health service appeals were upheld by the MCO appeals process.

NJFamilyCare Update

In her first MAAC meeting as the Medicaid Director, Meghan Davey, gave an update on NJFamilyCare. Almost 1.8 million enrollees are covered under the program. This represents 19.5 percent of New Jersey residents and roughly one third of all children in the state. Enrollment breakdowns by program, plan, age, gender and region are provided in Figure 4 below.

Figure 4 – NJ FamilyCare Enrollment by Program, Plan, Age, Gender, Region



All enrollees must seek redetermination for eligibility annually. While 20 to 25 percent are renewed administratively, the remaining enrollees must re-establish their eligibility with DMAHS. The Medicaid MCOs receive three monthly reports from the state to identify members whose redetermination is coming due: 1) HMO Renewal Report; 2) Cost Share Disenrollment Report; and 3) Non-Response to Renewal Report. The MCOs partner with DMAHS to remind members to take action on redetermination to avoid a discontinuation of Medicaid coverage.

Behavioral Health Update on Changes to the Provider FFS Reimbursement Rates

Valerie Mielke, Assistant Commissioner from the Division of Mental Health and Addiction Services (DMHAS) provided an update to the MAAC about the change in behavioral health service rates for services to Medicaid enrollees over 21 years of age and under 65. The new rates will go into effect in July 2016. The rate increases have a budget impact of $127.8 million of which $107.8 million will be covered under an enhanced federal match and third-party liability. A presentation that explains the rate development methodology and a comparison of old and new rates can be found here. DMHAS will hold regional Listening Sessions in May and June 2016 with providers to see how the transition is going.

The new rates include a "True Up" to enable NJ FamilyCare Plan A beneficiaries to access all substance use disorder (SUD) treatment services (intensive outpatient, outpatient, partial care, short term residential/non-IMDs, detox/non-IMD, IOP and opioid treatment); these services were previously only available to Medicaid expansion enrollees who qualified for these benefits under the alternative benefit plan. Before the True Up, NJ FamilyCare Plan A SUD services were limited to methadone treatment.

Provider Credentialing Update

Tom Lind, Medical Director for the Division of Medical Assistance and Health Services (DMAHS) provided an update of the Division's plans for implementing a state-run provider credentialing program. Dr. Lind explained that the original architecture for transitioning credentialing responsibility from the managed care organizations to DMAHS originally called for three phases by provider groups – Medical, Dental and Behavioral Health. A decision was made to merge Phase 1 and 2 and to accelerate the implementation from December 2018 to March 2017. This will cover all provider types currently defined under Medicaid Fee-for-Service and separately defined under managed care, as well as non-traditional provider types that offer long term services and supports. DMAHS will cross reference the Medicaid FFS specialty code provider types to the managed care provider types which will create a single approach for defining provider types. The credentialing contractor will codify the final set of provider types and enter them into the system. Once full implementation has occurred, MCOs will no longer have provider credentialing responsibility.

1115 Waiver Renewal

The state's Comprehensive Medicaid 1115 waiver will expire on June 30, 2017. To prepare for this, DMAHS has prepared a renewal package which will be released in mid-May for a 30 day public comment period. The renewal package details the proposed amendments to the waiver. Following public comment, DMAHS will review the comments, consider revisions to the renewal and submit the package to CMS for review and approval.

Transportation Broker RFP

DMAHS received three bids on April 14, 2016 in response to an RFP for a new non-emergent transportation broker contract. DMAHS hopes to award a new contract in late May or early June 2016.

HMA Medicaid Roundup

Alabama

Medicaid Agency Asking Lawmakers for More Funding. *The Montgomery Adviser* reported on April 20, 2016, that Alabama Medicaid Commissioner Stephanie Azar presented an overview of the agency's funding, spending, and eligibility requirements in a presentation to the joint committee of the Legislature. After asking for a $100 million funding increase, the Alabama Medicaid Agency only received $15 million. About 38 percent of the General Fund budget currently goes to Medicaid. Legislators, specifically those in the Senate, have been unwilling to reopen the 2017 budget. Absent additional funding, the resulting cuts may impact provider rates. Azar and Governor Robert Bentley also warned earlier this month that the state is looking at cuts to adult prescription drugs, outpatient dialysis, and hospice care for patients. Read More

Arkansas

Governor Hutchinson Extends Medicaid Expansion Using Line-item Veto, Needs Simple Majority to Hold Off Override Vote. *Kaiser Health News* reported on April 21, 2016, that Governor Asa Hutchinson has extended the Arkansas private option Medicaid expansion using a line-item veto and ending the two-week budget standoff. Governor Hutchinson's Arkansas Works expansion plan was blocked by 10 Republican senators, who threatened to defund the entire Medicaid program if expansion passed. As a result, Hutchinson added an amendment ending the program, and then line-item vetoed the amendment after two of the 10 holdouts approved the appropriation. Read More *Arkansas Business* reported on April 24, 2016, that discussions over Arkansas' three-year-old, alternative Medicaid expansion plan, Arkansas Works, are still ongoing between the Governor and legislators. Last week, Governor Asa Hutchinson vetoed a provision in the state budget that would have put an end to the program. Governor Hutchinson needs a simple majority to uphold his decision to continue the program if opponents try to override his veto this week. Read More

California

HMA Roundup – Don Novo (Email Don)

Medi-Cal Is Expanding Coverage to Children Regardless of Immigration Status on May 1. *The Sacramento Bee* reported on April 20, 2016, that beginning May 1, Medi-Cal will be expanded to approximately 170,000 children who entered or are residing in the U.S. without documentation. The expansion will

provide full coverage to all low-income children, regardless of immigration status, and is expected to cost the California Department of Health Care Services approximately $132 million annually. Washington, Illinois, New York, Massachusetts, and Washington, DC, all currently cover children regardless of immigration status. In California, about a quarter of uninsured residents under 65 are not eligible for coverage because of immigration status, according to a March 2016 report from the California Health Care Foundation. Read More

Covered California Announces Partnership with EyeMed Vision Care. Covered California, the state's health insurance Exchange, announced on April 26, 2016, that it has partnered with EyeMed Vision Care to provide vision benefits. EyeMed Vision Care will be responsible for conducting annual consumer surveys and quarterly enrollment reports. Enrollment will be available year-round with no open enrollment dates. Adult vision care is not an essential health benefit under the Affordable Care Act and will be handled directly through EyeMed Vision Care. Read More

Adventist Health to Acquire Three Rural Clinics from Colusa Regional Medical Center. The *Sacramento Business Journal* reported on April 21, 2016, that Adventist Health will acquire three rural health clinics from Colusa Regional Medical Center. Colusa is the city's only hospital and emergency medical center and has been preparing to close under financial strain. The three clinics provide non-emergency primary care and the deal will allow the clinics to continue providing care in Colusa County. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Long-term Care (LTC) Waiver Renewal Request. The state has submitted a request to CMS to renew its Long-term Care (LTC) 1915(c) waiver for a 5-year period, effective July 1, 2016. The 30 day public comment period will begin on Wednesday, April 27, 2016 and end on Friday, May 27, 2016. The state made the following changes in the renewal application which differ from the original approved waiver:

- revised the case management provider qualifications
- revised the performance measures
- updated the spousal impoverishment policy
- updated the waiver's personal needs allowance description
- updated the requirements related to physical therapy
- removed the structured family caregiving service
- updated the waiver specific home and community-based settings transition plan, and
- updated the waiver's unduplicated enrollee count and related waiver cost projections.

The draft Long-term Care Renewal Application can be found here.

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Illinois to Cap Home Health Worker Hours to Prevent Overtime. *Home Health Care News* reported on April 26, 2016, that after a federal ruling extending overtime and minimum wage protections to home care workers, Illinois will begin capping hours at 40 a week on May 1, 2016. Under the Illinois Home Services Program, workers will only be able to work 35 hours per week, plus 5 hours of travel time. State officials said without an approved budget, the state cannot afford to pay overtime. Additionally, there are concerns that if the budget stalemate continues, up to 25,000 seniors could be at risk of losing home health care services. Read More

New Mexico

HSD Proposes $160 Million Reduction in Medicaid Reimbursement Rates. The *AP/News & Observer* reported on April 26, 2016, that the New Mexico Human Services Department is proposing Medicaid provider reimbursement reductions amounting to $160 million in federal and state funds. The cuts would include a 3 percent to 8 percent reduction in Medicaid hospital reimbursement rates, the reversal of a previous increase in reimbursements to 2,000 general physicians, and the reversal of an increase in supplemental payments to 29 hospitals. The state is expected to save $26 million to $33 million in general fund dollars. The proposed cuts are part of an effort to close an $86 million gap for Medicaid services between now and mid-2017. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Strategic Redirection for Health + Hospitals. New York City mayor Bill DeBlasio has released a report on the status of the city's public hospital system, Health + Hospitals. Health + Hospitals is the largest publicly financed health system in the country with more than 40,000 employees in 11 hospitals and nearly 5,000 beds; five long-term care facilities with nearly 3,000 beds; and more than 70 community-based health care centers. The system serves more than 1.2 million New Yorkers, almost 70 percent of whom are uninsured or covered by Medicaid. The system is projected to have a $600 million budget shortfall this year. The report articulates a transformation plan for the system that includes four overarching goals, each of which includes numerous strategies designed to achieve the goals:

- Provide Sustainable Coverage and Access to Care for the Uninsured
    - Seek federal funding for a program that delivers coordinated healthcare services to the uninsured.
    - Ensure that Health + Hospitals does not bear the brunt of federal DSH cuts.
    - Comprehensive outreach to enroll people who are eligible for health insurance.

- Expand Community-Based Services with Integrated Supports that Address the Social Determinants of Health
    - Invest in new community-based care in underserved neighborhoods.
    - Invest in care management to improve quality and health.
    - Integrate government and community-based social services with health care services.
    - Develop vacant and under-utilized parcels on Health + Hospitals campuses to address the social determinants of health while raising revenue.
- Transform Health + Hospitals into a High-Performing Health System
    - Implement operational improvements building on existing efficiency initiatives.
    - Through a transparent process, restructure healthcare services system-wide to improve quality and lower cost.
    - Maximize revenue through MetroPlus Health Plan.
- Restructure Payments and Build Partnerships to Support the Health Outcomes of Communities
    - Move toward value-based payments.
    - Partner with other healthcare providers to build a comprehensive care management infrastructure to deliver patient-centered coordinated care

An analysis of the report in *Politico New York* notes that most of the ideas contained in the report are recycled and have so far failed to yield significant savings for Health + Hospitals. "At least nine of the report's 12 "strategies" have been tried, or are ongoing, and have so far failed to produce results as the public hospital system still faces a $1.8 billion deficit at the end of the decade." The report can be found here. Read More

Quality Measurement in New York State. The HealthCare Association of New York State has released a report on quality measurement in NYS. They argue that health care measurement and reporting is chaotic and in need of reform. They note that hospitals must report on hundreds of measures that are required by government and commercial payers, accreditation agencies, professional societies, and registries. They note that beneath each measure is a complex system of specifications, definitions, data abstraction, analysis, and reporting, all of which consumes significant time and resources. In addition, new measures are being developed to address the shifts in how care is paid for (volume to value). The report recommends that stakeholders, including hospitals and health systems, commercial payers, government agencies, and patient representatives, come together to streamline, align, and focus on those measures that are most important for advancing patient care.

- Streamline—commit to the minimum number of measures needed to evaluate healthcare quality, outcomes, and value;
- Align—with nationally-endorsed, evidence-based measures;

- Focus—on only those measures that target the most vital aspects of care, are actionable, tailored to the patient population, and offer opportunities to directly and positively impact patient outcomes;
- Collaborate—with key healthcare stakeholders, including patients, payers, regulators, and providers, to coordinate efforts.

Read More

DSRIP and Lessons Learned. The Commonwealth Fund has released a report on NY's DSRIP program and the implications for Medicaid payment and delivery system reform. The report focuses on five areas that have broad implications for stakeholders pursuing Medicaid-driven delivery system reform: organization, governance and market transformation; care model and social determinants of health; data-sharing and analytics; measurement and accountability; and value-based payment (VBP) arrangements and sustainability. Across each of these topics, they describe the New York approach, assess the early successes and challenges, and identify how New York's experiences can influence new state payment and delivery system reform initiatives. The report notes that while the long-term role of performing provider systems is uncertain, DSRIP is acting as a change agent for providers. It notes that the sustainability of PPS investments in new models of care is unclear, but that PPSs are, in fact, investing in community-based care. Finally, in looking at value-based payment arrangements, they note that the ultimate relationship between PPSs and managed care plans is unclear, that value-based payment requirements may incentivize provider consolidation, and that payment levels matter; the shift from fee-for-service to value-based payments do not solve the underlying economic issue of low reimbursement. Read More

NY Hospital Safety Scores Drop. *Crain's HealthPulse* reports on the latest Hospital Safety Score report put out by the Leapfrog Group. New York's ranking dropped from 34th to 44th over the last year. Of the 143 NYS hospitals that are included in the report, only ten percent received an A rating; 4 hospitals received an F. Read More

Insurance Plans Required to Cover Drugs for Hepatitis C. After an investigation by NY Attorney General Eric Schneiderman, seven health plans are revising their criteria for coverage of drugs to treat Hepatitis C. The investigation showed a wide discrepancy in how companies cover these drugs and found some insurers covered only patients with advanced stages of the disease. As part of their agreements, these seven insurers must cover medication for patients who don't have advanced disease, and cannot deny treatment for patients based on alcohol or drug use. According to the Wall Street Journal, Medicaid plans are updating their policies in consultation with the department's recommendations to reduce restrictions consistent with changes being made by commercial plans. Read More

DSRIP Mid-Point Assessment. As part of NY's DSRIP program, the state is required to conduct a mid-point assessment of implementation. After a public comment period, a revised version of the mid-point assessment process has been released. The most significant change to the document is in allowing Performing Provider Systems to include project-specific narratives detailing challenges encountered and mitigation strategies developed, and changes in the population served as a result of ongoing community needs assessments. PPSs will also have the ability to submit narrative on overall implementation efforts, including governance, workforce, cultural competence and value-based purchasing. In

addition, PPSs will have to undergo a Financial Stability Test. Based on the findings of the mid-point assessment, the state can decide to consolidate PPSs, or discontinue specific projects. The mid-point assessment will begin with the first quarterly report for DSRIP year 2, covering the period April – June 2016. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Department of Medicaid Holds First Public Hearing on Medicaid HSA Payments. *The Columbus Dispatch* reported on April 23, 2016, that the Ohio Department of Medicaid held the first of two public hearings on the draft 1115 waiver that would require certain Medicaid recipients to contribute 2 percent of their income up to $99 a year to a health savings account. State officials say the plan could cause 15 percent of Medicaid beneficiaries to drop out. During the public hearing, about a dozen people spoke out against the plan. Opponents say the plan could undo the progress of Medicaid expansion, decrease health care access among low income individuals, and increase emergency room use for simple health care needs. Medicaid recipients impacted by the plan would include those being treated for breast and cervical cancer, teens leaving foster care, and working-age, nondisabled adults. Read More

Mid-Session Budget Proposals Target Opioid, Heroin Addiction. *The Associated Press* reported on April 13, 2016, that Ohio Governor John Kasich is proposing a number of initiatives to address prescription opiate and heroin addiction in the state. The proposals, which are part of the mid-session budget review process, include licensing of pharmacy technicians. Doctors, dentists and other healthcare workers in private practices would also have to be licensed by the pharmacy board to distribute controlled substances. Other measures would increase availability of anti-overdose drugs and addiction treatments; waive requirement that providers must be certified in the state for two years before opening a methadone clinic; and cap painkiller prescriptions at 90 days. Read More

Disability Rights Ohio Files Class Action Lawsuit Against State. *Cleveland.com* reported on March 31, 2016, that Disability Rights Ohio filed a class-action lawsuit against Governor John Kasich and the directors of the state Department of Developmental Disabilities, Department of Medicaid, and Opportunities for Ohioans with Disabilities. The advocacy group claims individuals with disabilities who are institutionalized are illegally segregated, and that those who want to live and work in their communities cannot because of limited state funding. Of the 5,800 individuals living in large intermediate care facilities, 2,500 are on a wait list for a Medicaid waiver to receive services at home. An additional 22,000 individuals not institutionalized are on the wait list as well. Services for individuals with developmental disabilities in Ohio are provided through each of the state's 88 counties. Medicaid waivers for home and community services are partially funded with local dollars. Last year's state budget allocated $300 million to expand community-based options for individuals with disabilities. Read More

Medicaid Fraud Control Unit Leads Nation in Convictions. The *Sentinel Tribune* reported on March 31, 2016, that Ohio's Medicaid Fraud Control Unit had the highest number of convictions of all fraud control units in the nation in

fiscal year 2015. The unit is responsible for investigating and prosecuting health care providers that have committed fraud in the state's Medicaid program and protects individuals with disabilities and mental illness from abuse in long term care facilities. 160 individuals were convicted after investigations last year. Read More

Oklahoma

Medicaid Rebalancing Plan Gains Support; Funding Concerns Continue. *Tulsa World* reported on April 24, 2016, that while state legislators support the Oklahoma Health Care Authority's (OHCA) four-year Medicaid rebalancing proposal in theory, there are concerns over funding. OHCA is asking for $180 million in cigarette tax funding to avoid provider reimbursement cuts in the traditional SoonerCare Medicaid program, plus $100 million in startup funds to expand coverage to 175,000 uninsured adults through Insure Oklahoma, a premium-assistance program for low-income residents whose employers offer health insurance. Additionally, the proposed plan would move 175,000 SoonerCare members, many pregnant women and children, into Insure Oklahoma, reducing Medicaid enrollment by 17 percent. Legislators are concerned about the ability to fund the redesign given the state's projected $1.3 billion decline in revenue in the upcoming budget year. Read More

Oregon

LifeWise Health Plan Leaving Oregon. *The Oregonian* reported on April 21, 2016, that LifeWise Health Plan of Oregon will leave the state's health insurance market after posting losses of $36 million in 2015. Individual coverage will end at the end of this year and group plans will end at the end of their term, in 2016 or 2017. LifeWise will continue to provide coverage in Washington and Alaska. The company had around 50,000 Oregon members in 2015. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Announces HealthChoices Rebid Awards. On April 27, 2016, the Pennsylvania Department of Human Services (DHS) announced awards across the five statewide zones for the HealthChoices Medicaid managed care program. DHS announced awards for a total of eight health plans, with Centene's Pennsylvania Health and Wellness the lone new entrant. Many of the other seven MCOs will see an expansion or contraction of their number of zones served. DHS awarded five plans each in the Southeast (SE), Southwest (SW), and Lehigh/Capital zones, and four plans each in the Northeast (NE) and Northwest (NW) zones. The HealthChoices program covers an estimated 2.1 million Medicaid beneficiaries, with annual spending of more than $10 billion. New contracts will set expectations for MCOs to increase their percentages of value-based or outcomes-based provider contracts. The eight health plans selected for awards follow.

	Southeast Zone	Southwest Zone	Lehigh/ Capital Zone	Northwest Zone	Northeast Zone
Aetna Better Health, Inc				X	
Centene (Pennsylvania Health and Wellness)	X	X	X		
Gateway Health		X	X		
Geisinger Health					X
Health Partners Plan	X				
United Healthcare of Pennsylvania, Inc	X	X	X	X	X
UPMC for Your, Inc	X	X	X	X	X
Vista**	X	X	X	X	X

***Vista-Keystone First Health Plan will operate in the SE Zone and Vista-AmeriHealth Caritas Health Plan will operate in the Lehigh/Capital, NW and NE Zones.*

The full awards announcement is available here.

Draft 2017 MIPPA Contract Posted by DHS; Comments due by May 4. The Department of Human Services has posted for comment a draft Medicare Improvements for Patients and Providers Act contract that will govern all dual eligibles who enroll in D-SNPs, including those who choose a companion D-SNP in the Community HealthChoices (CHC) program. DHS has focused its reporting requirements on data that CMS already requires D-SNPs to submit. Here are some key points from the draft 2017 MIPPA Contract:

- Beginning January 1, 2018, CHC-MCOs will be required to have companion D-SNPs that match the regions and service areas of their CHC-MCOs, to ensure that all CHC members have the option of integrating their Medicare and Medicaid benefits.
- Dual eligibles that do not actively choose a Medicaid CHC-MCO, and who are already enrolled in a companion D-SNP, will be automatically enrolled in its aligned Medicaid CHC-MCO. However, they will have the option to choose a different Medicaid plan at any time.
- Companion D-SNPs will be required to work with the CHC Independent Enrollment Entity so it can better counsel participants on their options for integrated Medicare benefits.
- An MCO must provide a single point of contact for a member who chooses both its CHC-MCO and its companion D-SNP.
- Non-companion D-SNPs (those not aligned with a CHC-MCO) are also eligible for MIPPA contracts and may serve any combination of dual eligibles permitted by CMS.

Those who want to submit feedback may review the draft MIPPA Contract and must use the designated form to provide comment by May 4. Read More

OLTL's Community HealthChoices Home and Community-Based Waiver Available. Pennsylvania's Department of Human Services Office of Long Term Living (OLTL) is making available for public review and comment the proposed Community HealthChoices (CHC) 1915(b) waiver and the proposed CHC 1915(c) waiver amendment which, if approved, will govern operation of the CHC Program, PA's managed long-term services and supports initiative. OLTL will offer two webinars on May 12, 2016 2:00-3:30 pm and May 18, 2016 10:00-11:30 am. The public comment period ends May 23, 2016. Read More

UnitedHealthcare to pull out of Pennsylvania's ACA Market. UnitedHealthcare is exiting Pennsylvania's Affordable Care Act health insurance market next year. UnitedHealthcare has 289,131 ACA members in 23

counties of Pennsylvania, less than one-third of the 439,235 individual marketplace members statewide, according to a new study by the Henry J. Kaiser Foundation. Read More

Texas

Clarification on Texas 1115 Waiver Demonstration Extension Request. Last week, on April 20, 2016, the *HMA Weekly Roundup* included a story on the Texas Health and Human Services Commission's (HHSC) request for an extension of Texas' 1115 Demonstration waiver. Unfortunately, the article included an inaccurate statement indicating that federal officials had said they would not extend the waiver if the state did not expand Medicaid. No such condition has ever been communicated by federal officials to HHSC. In fact, negotiations with CMS and HHSC are progressing and the State expects an agreement will be reached soon. We regret any confusion this error has created and apologize to our readers and to the Texas Health and Human Services Commission.

Texas Health and Human Services Commissioner Announces Retirement. Chris Traylor, head of the Texas Health and Human Services Commission (HHSC), announced on Friday that he will retire at the end of May. Traylor was appointed last June when former commissioner Kyle Janek left after several high profile problems with government contracts. Traylor was previously Janek's Deputy Commissioner and had just announced his own retirement when he was tapped by Governor Abbott to replace Janek. Under the HHSC umbrella, Traylor is responsible for oversight of the Health and Human Services Commission, the Department of State Health Services, the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, and the Department of Family and Protective Services. Programs under his administration include Medicaid, CHIP, the Texas Women's Health Program, SNAP Food Benefits and Nutritional Programs, Foster Care Services, Family Violence Services, Refugee Services, and Disaster Assistance.

Traylor leaves at a time when the Commission is undergoing a significant organizational restructuring and implementing numerous programmatic changes as a result of legislation enacted in 2015. HHSC also is in the midst of CMS negotiations on the renewal of the state's Medicaid Section 1115 Demonstration Waiver, which ends in September but is expected to be renewed. In a statement last summer following the legislative session, Abbott said Traylor would "make needed reforms to ensure that the millions of Texans who rely on the vital services HHSC performs are able to have the utmost trust in the agency." Abbot has not yet named a replacement for Traylor.

Appeals Court Upholds $350 Million Medicaid Therapy Cuts. *The Houston Chronicle* reported on April 21, 2016, that the state Third Court of Appeals dismissed a challenge to the $350 million reductions in reimbursement rates for therapists who serve Medicaid beneficiaries. The court also reversed a temporary injunction on the cuts. Providers and parents say the cuts will be devastating for as many as 60,000 children with disabilities. Their case stated that the impact of the reimbursement cuts was not properly studied and would lead to fewer providers serving Medicaid recipients. The court ruled that the Health and Human Services Commission acted within its rights to implement the cuts because Medicaid participants are not guaranteed access to specific providers. State officials said the number of Medicaid therapy providers grew 30

percent between 2009 and 2014 and rates were already higher than in many other states. Read More

West Virginia

DHHS Says Budget Deficit May Impact Medicaid Provider Payments. *WV Public Broadcasting* reported on April 25, 2016, that the West Virginia Department of Health and Human Resources issued an alert to Medicaid providers on April 25, warning them that the Department may not be able to "continue to process claims at the same consistent level" because of budget shortfalls. The Department of Revenue reported that the state is $146 million short of the amount needed to fund the government through the end of the fiscal year, ending June 30. Although the Governor and legislature have not yet reached an agreement on funding, a potential compromise may include budget cuts, revenue increasing measures, and the use of one-time funds such as the Rainy Day Fund. Read More

Wisconsin

DHS Projects $300 Million in Savings Over Six Years from Long-Term Care Privatization. The *AP/Charlotte Observer* reported on April 22, 2016, that the Wisconsin Department of Health Services (DHS) projects that transitioning the Family Care and IRIS managed care programs to a system of integrated acute and long term care would save the state $300 million over six years. Under the proposal, DHS would contract with integrated health agencies (IHAs) across three zones, with three IHAs serving each zone. Advocates are concerned that zoning might lead to smaller providers going out of business. The department is currently seeking approval from the Joint Finance Committee before the proposed plan can go to federal review. Read More. Click here to view the March 30, 2016 HMA *In Focus* on the Family Care/IRIS LTSS redesign.

National

CMS Releases Final Medicaid Managed Care Rules. *Kaiser Health News* reported on April 26, 2016, that the final Medicaid managed care regulations released by CMS include a number of changes for Medicaid managed care plans. Some of the reforms include requirements for adequate physician networks, an 85% minimum MLR for plans, regularly updated provider directories, reporting of fraud and abuse, collection of patient data, and quality reporting. The new rules will be implemented over the next few years beginning July 1, 2017. Read More

Industry News

Centene Considers Entering Additional Exchange Markets. *CQ Roll Call* reported on April 26, 2016, that Centene is considering expanding its Exchange presence, likely targeting states where it currently participates in Medicaid. The company is currently participating in the Exchange in 13 states. Centene also indicated that it would offer new Medicare Advantage products in four new states. Other insurers have also indicated interest in expanding their Exchange presence, while United Healthcare announced that it would be exiting most of the Exchanges.

Anthem, Cigna Affirms Commitment to ACA Exchanges. *Fox Business* reported on April 20, 2016 that Cigna and Anthem have decided not to exit the Affordable Care Act insurance Exchanges. Cigna has stated its intent to expand its geographical presence on the Exchanges in 2017. Anthem and Cigna are awaiting federal and state approval of their merger. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
April 29, 2016	Missouri (Statewide)	RFP Release	700,000
April, 2016	Virginia MLTSS	RFP Release	130,000
April-May, 2016	Minnesota SNBC	Contract Awards	45,600
May, 2016	Massachusetts MassHealth ACO - Pilot	Applications Open	TBD
May 2, 2016	Pennsylvania MLTSS/Duals	Proposals Due	420,000
May 11, 2016	Indiana	Cost Proposals Due	900,000
May, 2016	Oklahoma ABD	DRAFT RFP Release	177,000
June, 2016	Indiana	Contract Awards	900,000
July 1, 2016	Missouri (Statewide)	Proposals Due	700,000
July 1, 2016	West Virginia	Implementation	450,000
July 1, 2016	Minnesota SNBC	Impementation (Northern Counties)	45,600
July, 2016	Georgia	Implementation	1,300,000
August, 2016	Oklahoma ABD	RFP Release	177,000
July-August, 2016	Massachusetts MassHealth ACO - Full	Applications Open	TBD
September 1, 2016	Texas STAR Kids	Implementation	200,000
September, 2016	Massachusetts MassHealth ACO - Pilot	Selection	TBD
October 1, 2016	Missouri (Statewide)	Contract Awards	700,000
October, 2016	Oklahoma ABD	Proposals Due	177,000
November 1, 2016	Arizona ALTCS (E/PD)	RFP Release	30,000
December, 2016	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
December, 2016	Massachusetts MassHealth ACO - Full	Selection	TBD
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Nebraska	Implementation	239,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
January 1, 2017	Minnesota SNBC	Implementation (Remaining Counties)	45,600
January 18, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
March 1, 2017	Virginia MLTSS	Implementation	130,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October, 2017	Massachusetts MassHealth ACO - Full	Implementation	TBD
TBD 2017/2018	Oklahoma ABD	Implementation	177,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

Below is a summary table of the progression of states toward implementing a dual eligible financial alignment demonstration.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (April 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	431,000	123,981	28.8%	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Illinois	Capitated	4/1/2014	6/1/2014	148,000	48,272	32.6%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	94,000	12,307	13.1%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	105,000	31,766	30.3%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	124,000	5,617	4.5%	There are 17 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
Ohio	Capitated	5/1/2014	1/1/2015	95,000	61,535	64.8%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	12/1/2015	2/1/2016	30,000			Neighborhood INTEGRITY
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	5,954	11.1%	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	45,219	26.9%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	70,500	27,116	38.5%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,319,100**	**361,767**	**27.4%**	

Note: Enrollment figures in the above chart are based on state enrollment reporting, where available, and on CMS monthly reporting otherwise.

HMA News

HMA Information Services Launches Daily Roundup

HMA Information Services is pleased to announce the launch of the *Daily Roundup*, which includes breaking industry news and state-by-state updates from HMA consultants in the field. The *Daily Roundup* will be available only to HMAIS subscribers and will include advance content from *the HMA Weekly Roundup*, which will otherwise remain unchanged and continue to be distributed to readers every Wednesday evening. For more information about the Daily Roundup please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

HMA Upcoming Webinars

"Understanding the Impact of the Mental Health Parity and Addiction Equity Act – Final Regulations"

May 11, 2016

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"Using a Policy Framework to Foster Provider Practice Transformation: How the District of Columbia Launched Major Delivery System Change through its Medicaid Health Home Program for Individuals with Serious Mental Illness"

May 12, 2016

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"Marrying Strategic, Operational and Information Technology Planning: Two Separate Frameworks in Support of Common Goals for Healthcare Organizational Efficiency and Effectiveness"

May 17, 2016

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Register Now

"Patient-Centered Medical Home Transformation: The Right Thing to Do for Patients and for Your Organization"

May 18, 2016

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